Medicaid
Provider Training

DDS.Waiver@ct.gov

Best Practices

We will go over:

- MyAccount
- DSS forms
- How to get individuals back on Medicaid
- Coverage Groups
- Best Practices

MyAccount

- You can complete:
  - New applications
  - Renewals
- You can upload:
  - Status changes (new address, new arep, etc.)
  - Verifications requested
- Keep record of the submission ID#’s
- Community Partners

W-1E
(Rev. 3/17)

State of Connecticut
Department of Social Services
W-1E Application for Benefits

Apply Faster Online!
ConnectCT
Visit www.connect.ct.gov
instead of using this form.

Who are you applying for? Check one box.	**What kind of help are you applying for?** Check all that apply.
Complete all sections with this exclamation icon (picture).	**Complete all sections that match the icons (pictures) for each program you select.**
☐ Only myself	☐ Food (SNAP - Supplemental Nutrition Assistance Program)
☐ Myself and my spouse	☐ Cash
☐ Myself and my family	☐ Medical (HUSKY/ Medicaid/ health insurance)
☐ Only children under 19 in my care	☐ Special medical help to pay for unpaid medical bills from the past 3 months

Is anyone in the household pregnant?	☐ Yes	☐ No
Does anyone applying live in a licensed residential care facility (boarding home)?	☐ Yes	☐ No

Answer the following questions if you are applying for SNAP:

Complete sections with the apple icon (picture) if applying for food help.

Is your household's total income less than $150 a month (before taxes)?	☐ Yes	☐ No
Do your household's cash and bank accounts total less than $100?	☐ Yes	☐ No
Is the total of your household's monthly income, cash, and bank accounts less than the total of your housing and utility costs for the month?	☐ Yes	☐ No
Is anyone in your household a migrant or seasonal farm worker?	☐ Yes	☐ No

Do you need a reasonable accommodation or extra help getting benefits because of a disability or impairment?

☐ Yes ☐ No If yes, describe your condition and the help you need.

Person 1 Tell us about the people in your household, starting with yourself.

My name (first, middle, last, suffix)			Legal or other name (if different)	
Client ID (if known)			Social security number	
Gender	Preferred spoken language		Do you need an interpreter? ☐ Yes ☐ No	
Date of birth	Best phone number		Phone type ☐ Home ☐ Work ☐ Cell	
☐ No home address	Home street address	City	State	Zip
Mailing address (if different)	Mailing street address	City	State	Zip

By signing, I agree that:
- **I have read this form including the section about rights and responsibilities listed at the end of this application, or have had it read to me in a language that I understand, and that I must comply with these rules;**
- **The information I am giving is true and complete to the best of my knowledge, including all information about citizenship, alien and felon status;**
- **I could go to prison or be required to pay fines if I knowingly give wrong or incomplete information; and**
- **DSS and other federal, state, and local officials may verify (check) any information I give.**

Print your or representative's full name	Signature	Date
Print full name of any other adult applicant	Signature	Date

State of Connecticut
Department of Social Services
Long-term Care/Waiver Application

Client ID:

Items Needed for Your Long-Term Medical Care / Home Care Application

KEEP PAGES 1 and 2 FOR YOUR RECORDS

If you do not already get Long-Term Care Medical Assistance or Home Care Assistance from the Department of Social Services, we need the items listed below to process your application. Send copies, **do not send originals.** In some cases, we may request more documents than those listed below. If we do, we will give you time to send us them. If you do not have, or if you need help getting the needed documents, contact DSS for help.

DO NOT WAIT TO APPLY

If you do not have copies of all the documents listed, send us what you have when you apply. It is important that you apply as soon as possible. We will give you more time to send the other documents we need.

Each month you will need to pay a portion of your income to the nursing home; this is called applied income. A married applicant may be able to give a part of their income to their spouse in the community. The following is needed to make this determination:

- ☐ Spouse's monthly gross income
- ☐ Condo fees
- ☐ Mortgage payment
- ☐ Lot rental amount
- ☐ Property tax bill
- ☐ Rent/Lease
- ☐ Electric bill
- ☐ Homeowner's insurance

The following documents are needed from you and your spouse to determine if you are eligible for Long-Term Care Medical Assistance or Home Care Assistance from DSS:

☐ Federal law requires DSS to review 5 years of bank and financial statements on all accounts owned and co-owned by you and your spouse. DSS does this by reviewing 2 full years of statements from the date of application including the current month and statements for December of the remaining 3 years showing the year to date interest. If you cannot provide the statements for the 3 remaining years you can provide your federal tax returns. You must also explain any deposits or withdrawals of $5,000.00 or more.

- ☐ Stocks
- ☐ Bonds
- ☐ Money Market Funds
- ☐ Certificates of Deposit
- ☐ Mutual Funds, Treasury and other notes
- ☐ Retirement Accounts
- ☐ IRA and Keogh Accounts
- ☐ Annuities (a copy of the original annuity contract in addition to the statements)
- ☐ Trusts

☐ Current gross monthly income from all sources including:

- ☐ Social Security
- ☐ Railroad Retirement
- ☐ VA Pensions
- ☐ Private pensions
- ☐ Annuities (a copy of the original annuity contract in addition to the statements)

W1E

- Submit new application online, if possible.
- Difference between W-1E and W-1LTC
- New applications can be sent to DDS.Waiver@ct.gov for DDS individuals only!
- Ensure it is sign and benefits marked
- If benefits have been terminated for over 30 days a W-1E is needed.
- DSS considers this “Long Term Care” (LTC)

W-1ER (Rev. 6/14)

State Of Connecticut
Department Of Social Services
Renewal Of Eligibility

Head Of Household
Client ID Number
_____

This renewal form is only for current DSS clients who get one or more of the following:

- Supplemental Nutritional Assistance Program (SNAP)
- Cash Assistance (including boarding home payments)
- Medical Insurance (HUSKY) **only** if you are:
  - (1) 65 years old or older;
  - (2) on Medicare;
  - (3) determined disabled by DSS and are working;
    or
  - (4) receiving Long-Term Care

If you get HUSKY and you are not in one of these four groups then you cannot renew with this form. You must renew online at www.CONNECT.ct.gov or by phone with our partner Access Health CT at (855) 805-4325. You can also call (855) 805-4325 and ask for a paper form. Renewing online is fastest.

This form is only to renew eligibility for the benefits you get now or to add new members of your household. You must fill out the form and sign and date page 6 for it to be complete.

Call us if you need help filling out this form or getting proof: (855) 626-6632. To apply for help that you do not get now, apply online at www.CONNECT.ct.gov. You can also ask us to mail you a paper application.

Do you need a reasonable accommodation or extra help getting benefits because of a disability or impairment? ☐Y ☐N. If yes, what kind of assistance do you need? _____

_____

Section 1: Head Of Household (you)

First Name	Middle Name	Last Name	(Maiden Name)	Best Phone #	Other Phone #

Home Street Address	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

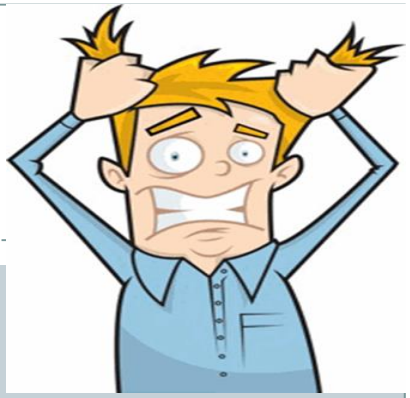
Section 2: Household Members

- List members of your household starting with you.
- If you want to add a person to your household, list them here and in Section 4.

Name (First, Middle, Last)	Date of Birth	How Related to You	Gender (M or F)	Marital Status*	Buy/cook food with you?	Renew or Add household member
1 Myself		Self				☐Renew ☐Add
2					☐Y ☐N	☐Renew ☐Add
3					☐Y ☐N	☐Renew ☐Add
4					☐Y ☐N	☐Renew ☐Add
5					☐Y ☐N	☐Renew ☐Add
6					☐Y ☐N	☐Renew ☐Add

*Marital Status: N = never married M = married D = divorced S = separated W = widowed

W-1ER



- Complete renewals online, if possible
- Submit or upload verifications with renewal
- Send 40 days prior to the due date
- Separate renewal needed for every benefit if renewal is due at a different date. If on same date, one renewal is sufficient.
- Paper renewals go to the scanning center. Copies to DDS.Waiver@ct.gov
- Send renewal even if you do not receive a renewal form in the mail.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

W-265
(Rev. 6/17)

REPORT OF ADMISSION OR DISCHARGE
RATED HOUSING FACILITY/RESIDENTIAL CARE HOME

Client Name: _____ Client ID#: _____

Facility Name: _____ Vendor ID#: _____

Facility Address: _____ Facility ph#: _____

☐ **ADMISSION** Date of Admission: _____

Admitted From: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility from which the individual was admitted: _____

☐ **DISCHARGE**

☐Notice of Permanent Discharge Date of Discharge: _____

☐Notice of Temporary Discharge Date of Discharge: _____

If a temporary discharge, is the individual expected to return by the last day of the month following the month of discharge? ☐Yes ☐No *

If no, when is the individual expected to return _____

Are you holding the bed for this individual? ☐Yes ☐No *

Discharged to: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility to which the individual was discharged: _____

Completed by: _____ Date: _____
Print Name

_____
Signature

This form is not a request for assistance. Please notify the Department of Social Services (DSS) **within 10 days** of any changes in living arrangements for DSS clients.

To order additional forms, send request on your agency letterhead to:
DSS, Document Center, 55 Farmington Ave., Hartford, CT 06105 FAX: (860) 424-4954
Please include a complete mailing address, form number and the quantity needed.
Please note forms cannot be mailed to P.O. Boxes.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired, can contact DSS at 1-860-424-5040.

W-265

- CLA's only
- W-265 is needed when there is a new admission, transfer or discharge.
- One form for admission and one for discharge
- Ensure to put Vendor ID#, admission or discharge date and it is signed by authorized rep

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

W-298
(Rev. 11/14)

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name of DSS Client _____ **Client ID or S.S. #** _____

I authorize DSS to disclose the information indicated below to: (name and address of person to receive information)

Agency name only!

_____

for the following purpose(s):

_____

(If you do not wish to state a purpose, you may write "at my request."

Type of Information DSS is Authorized to Disclose (check all that apply):

☐ PHI (other than mental health, substance abuse and HIV-related records) ☐ mental health records*

☐ substance abuse treatment records** ☐ HIV related information***

☐ DSS application and documentation relating to benefits applied for, received or receiving

☐ other _____
(Please specify)

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from DSS.
- I understand that I may revoke this authorization at any time by notifying DSS, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.

This authorization expires on _____ (Date) or upon _____ (Event). (If use or disclosure of PHI is for research, including the creation and maintenance of a database, write "end of research study" or "none.")

X _____ Date: _____

Signature of DSS Client or Person with Legal Authority to Sign for Client
(Attach copy of designation as Conservator/ Power of Attorney/ Guardian)

Printed Name of Person Who Signed _____

Note to Recipient of Information:

* The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise, permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*** **HIV Related Information:** This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524.
Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

W-298

- Signed by individual or guardian with current date
- Ensure that guardianship paperwork is submitted to DSS.
- Form should have agency name only
- Only needed when there is a new guardian or arep

W-1685
(Rev. 3/05)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

MEDICAL INSURANCE INFORMATION

For Worker's Use Only:
☐ New Insurance ☐ Change in Insurance
HOH Name_____ Client ID #_____
☐ Attached is a copy of the Medical Insurance Card (front and back)

Client Approved for Coverage Group S05 Medicaid For Working Disabled ☐ Yes ☐ No
Premium purchase requested? ☐ Yes ☐ No
Premium currently being paid by DSS? ☐ Yes ☐ No If Yes, to whom?_____

This form asks questions about medical insurance coverage for you and your family. This information is required for our computer file. We also need this information to determine whether we can pay for medical insurance premiums on your behalf.

Fill out a separate form for each policy. Please provide as much information as you can and return it to the local Department of Social Services office no later than _____.

Client Name_____ Customer Service Phone_____

Insurance Company Name_____

Insurance Company Address_____

What medical services are covered by this policy? Check all that apply:
☐ Hospital ☐ Doctor/Medical/Surgical ☐ Prescription ☐ Vision/Optical ☐ Dental ☐ Long Term Care

Policy Number_____ Group Number_____

Is this a Long-Term Care Partnership Policy? ☐ Yes ☐ No

Policy Effective Dates: Start_____ Stop_____

Premium Amount $_____ per _____ Premium Effective Date_____

IF THE INSURANCE IS HELD BY SOMEONE OTHER THAN YOURSELF, PLEASE FILL IN THE FOLLOWING:

Policy Holder's Name_____ Social Security Number_____

Policy Holder's Date of Birth_____

Policy Holder's Address_____

IF THE INSURANCE IS THROUGH EMPLOYMENT, COMPLETE BELOW:

Employer_____ Phone #_____

Employer's Address_____

LIST ALL PERSONS COVERED BY THIS MEDICAL INSURANCE POLICY BELOW:

Name	Date of Birth	Sex	List any major illness/ injury within last year	Worker's Use Only: Client ID #
1.				
2.				
3.				
4.				
5.				
6.				

I give permission to the Department of Social Services, the Connecticut Medicaid Agency, or any health insurer, provider, or any other entity providing services to me or my family under the Medicaid program to release information about me or my family as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or state law.

Client Signature_____ Date_____

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

W-1685

- Only if the individual has private insurance, other than Medicare
- Submit copy of insurance card front and back

W-849
(Rev. 4/04)

State of Connecticut- Department of Social Services

Legally Liable Relative (LLR) Form for Institutionalized Children Receiving Medicaid Long Term Care Services or Medicaid Home and Community Based Waiver Services

Applicant/Recipient Name_____

Parent(s) Name(s)._____ Phone#:_____

Parent(s) Address_____

If your child is receiving Medicaid long term care services or Medicaid Home and Community Based Waiver Services, we may require you to contribute to your child's cost of care. This amount cannot exceed the amount of assistance paid to or on behalf of the child by the Department of Social Services.

In order for us to determine your share of the cost of your child's care, we need the following information:

1. The father's net adjusted taxable income for the last calendar year; if applicable: *(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)* $_____
2. The mother's net adjusted taxable income for the last calendar year; if applicable: *(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)* $_____
3. The joint net adjusted taxable income of the father and mother for the last calendar year; if applicable: *(Attach a copy of your1040 tax form to verify your net adjusted taxable income.)* $_____
4. If you are divorced or legally separated and are under a court order to pay support please indicate your monthly court ordered support payment: *(Attach a copy of your court order verifying the payment amount.)* $_____
5. Any in-kind support provided by the parent(s) during the last calendar year while living with the child, along with verification of such support, which is over and above that provided to a healthy child. Examples of in-kind support include, but are not limited to, the following:

   cost of medical supplies which are not covered by insurance or Medicaid; $_____

   cost of special diet; $_____

   cost of special transportation; $_____

   cost of adaptations to a home to accommodate the special need of the child; $_____

   other *(please indicate specific service)* $

List below the people living in your household. Place a check mark (4) next to the names of those dependent on you for support

4	Name of Household Members	Age	Relationship

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

W-849

- Only for children, up to age 21.
- Submit with parents or guardians most recent tax returns
- Bank statement showing the child's SSI or SS deposit
- Statement showing how the child's income is spent

W-300T19
(New 1/16)

State of Connecticut
Department of Social Services

Medical Report
(For Title XIX Disability Determination)

Dear Medical Provider:

The patient named on page 2 has applied for assistance with the Department of Social Services (DSS) and has acknowledged physical and/or mental health problems. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for this assistance. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that precludes substantially gainful employment and is terminal or expected to last for at least 12 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, that pertain to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but feel free to use your own authorization form if you prefer.

Please return the completed form to: Colonial Cooperative Care
PO Box 2040
Manchester, CT 06045

Phone: 860-885-0630
Fax: 860-885-0631

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

Thank you for taking the time to provide information on behalf of your patient.

State of Connecticut
Department of Social Services

W-300MED
(New 1/16)

Medical Report
(For Medicaid for the Employed Disabled)

Dear Medical Provider:

The patient named on page 2 has applied for assistance with the Department of Social Services (DSS). He or she has acknowledged physical and/or mental health problems and is requesting Medicaid benefits. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for these benefits. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that precludes substantially gainful employment and is terminal or expected to last for at least 12 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, pertaining to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but feel free to use your own authorization form if you prefer.

Please return the completed form to: Colonial Cooperative Care
PO Box 2040
Manchester, CT 06045

Phone: 860-885-0630
Fax: 860-885-0631

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

Thank you for taking the time to provide information on behalf of your patient.

Medical Packet

- This is needed only when an individual has not been determined disabled by Social Security.
- The W-300T19 form is for individuals who are not working.
- The W-300MED is for individuals who are working.
- Either form has to be submitted with the W-303 and W-303a forms.
- The main form is completed by the physician.

MEDICAID COVERAGE GROUPS AND ACTIONS

Medicaid Coverage Groups	Description of Medicaid Groups	Action Needed for Waiver Enrollment for Case Manager	Action Needed for Waiver Enrollment for Providers
B01	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov
B02	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
B03	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D01	DCF group under age 18, eligible for adoption assistance or foster care payments.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D02	DCF medical coverage group.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D03	DCF coverage group under 21, for subsidized adoption.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D04	DCF coverage group, between 18 and 21 years and leaving foster care.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D05	DCF coverage group. State funded Medicaid coverage. Limited to selected community based Behavioral Health Services.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
X03	Husky A extended medical assistance for 12 mos. After exceeding income limits.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
F04	Husky A extended medical assistance for 12 mos. After exceeding income limits due to child support.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
F06	Husky A presumptive eligibility for kids while pursuing other eligibility.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
X07	Husky A for Parents and Caretakers/ families.	Section N (pages 11 & 12 of the W-1LTC app) to DDS.Waiver@ct.gov. Waiver packet to PRAT	Section N (pages 11 & 12 of the W-1LTC app) to DDS.Waiver@ct.gov.
F10/F11	Husky A for newborns for first 12 mos.	Applies to newborns/infants only.	Applies to newborns/infants only.
F12	Husky A for children 19 & 20 who do not receive SSI or SSDI. AFDC income & asset requirements.	Seek SSA and/or complete W-300T19 (if working W-300MED), W-303 & W-303A with T19 app to DDS.Waiver@ct.gov.	Seek SSA and/or complete W-300T19 (if working W-300MED), W-303 & W-303A with T19 app to DDS.Waiver@ct.gov.
X25	Husky A for children.	Section N (pages 11 & 12 of the W-1LTC app) to DDS.Waiver@ct.gov. Waiver packet to PRAT	Section N (pages 11 & 12 of the W-1LTC app) to DDS.Waiver@ct.gov.
F95	Husky A for medically needy children under 21 years of age.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
F99	Husky A spend down that should be closed and referred to Husky B.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
X01	Husky A for pregnant women	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.

T19 Coverage Groups

- Coverage groups
- W01 – Waiver medical. Renewed yearly. Income limit $2,349 (3x's the amount of SSI). Asset $1,600.
- S05 – Med-ConneCT. Income limit $75,000. Asset $10,000. Verifications every 6 months
- S01 – Cash. Renewed yearly. Income limit $523.38. Asset $1,600. (Income eligibility depends on each individual's case).
- Husky D/A switches- email DDS.Waiver@ct.gov

DDS STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

460 Capitol Avenue, Hartford, Connecticut 06106 ◆ Phone: 860/418-6000 ◆ Fax: 860/418-6001 ◆

DDS Maintaining Medicaid Eligibility equals Waiver Eligibility

Updated December 2017

Maintaining Medicaid Benefits is really Important!

You must complete your DSS redetermination of eligibility on time!

Your DDS Waiver services are at risk of being discontinued if Medicaid Eligibility is not maintained.

Medicaid requires an annual redetermination application. **You must complete it as soon as you get it.** It is called "State Of Connecticut Department Of Social Services Renewal Of Eligibility W-1ER". It is due **6 weeks before your Medicaid expires** if you do not do this before the 6 weeks you will be discontinued from benefits and forced to reapply for Medicaid. If you are receiving any services from DDS such as; a day program, case management etc. These services are paid through the Medicaid system so it is really important to maintain that benefit.

Link to redetermination form: https://portal.ct.gov/DSS/Search-Results?SearchKeyword=W-1E **in English & Spanish**

Medicare Savings Program

If you have applied for the Medicare Savings benefit /waiver (aka QMB or Q01)you also have to do a redetermination application separately each year. If you do not do the application the benefit will be taken out of your monthly Social Security check.

Medicare Savings program English & Spanish - https://portal.ct.gov/DSS/Search-Results?SearchKeyword=MSP

Fact Sheet

- Various information
- Where to send premium payments
- Asset reduction information
- Spend down
- Scanning Center address
- DDS Waiver Contacts

MyAccount Guide

How to Get Started
Cómo empezar

1. Click **Create an Account** link on main landing page *(see image below)*
2. Registration page appears
   - Enter first and last name
   - Email address is optional
   - Create unique user ID and Password
   - Select 4 secret questions and answer them
   - Click "user acceptance" box
   - Associate MyAccount to the client ID, if you have a client ID

For technical support call 877-874-1612
Para apoyo técnico llame al 877-874-1612
www.connect.ct.gov

If you skipped typing your client ID in during registration, don't forget to go back and "Associate Your Case."

Si has omitido de ingresar su número de identificación de cliente durante su registración, no olvides de regresar y "Asociar su caso."

1. Haga clic en el enlace de **Crear un Cuenta** en la página principal de aterrizaje *(ver la imagen a continuación)*
2. Aparece la página de registro
   - Ingrese el nombre y apellido
   - Dirección de correo electrónico es opcional
   - Crear identificación de usuario y contraseña únicos
   - Seleccione 4 preguntas secretas y dar respuestas para cada una
   - Haga clic en aceptación de usuario
   - "MyAccount" debe ser asociado con su número de cliente, si lo tiene

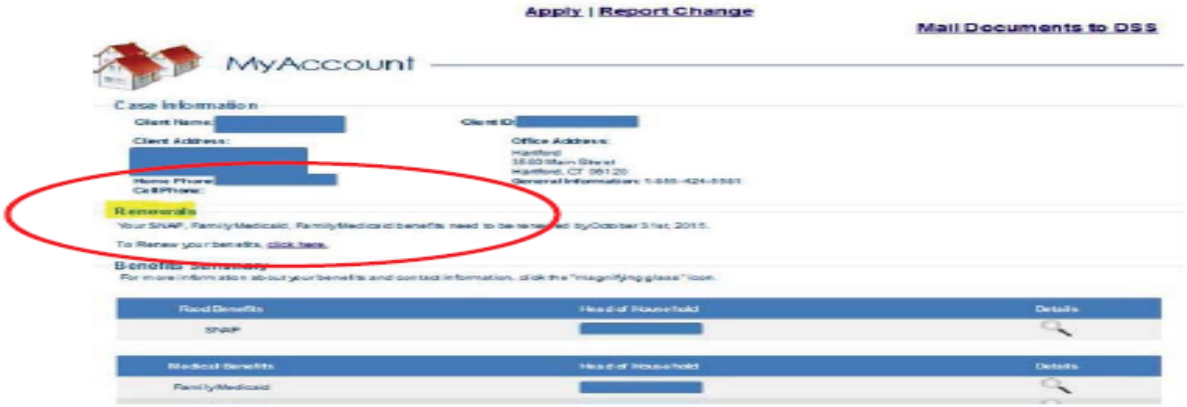
Online Renewals
Renovaciones En Línea

If a customer has set up a MyAccount that has been associated to his or her client ID, *and is within 60 days of a renewal due date*, a link will appear on their MyAccount home page to complete the renewal online. (*The "Renewals" section is highlighted below)* For more information, please visit:
www.ct.gov/dss/renewal

Si el cliente ha creado su cuenta asociado con su número de identificación de cliente, y está dentro *de los 60 días de la fecha de vencimiento*, un enlace aparecerá en la página principal de su MyAccount para completar su renovación en línea. (*La sección de "Renovaciones" ha sido enfatizada a continuación*) Para más información, por favor visítenos al: www.ct.gov/dss/renewal

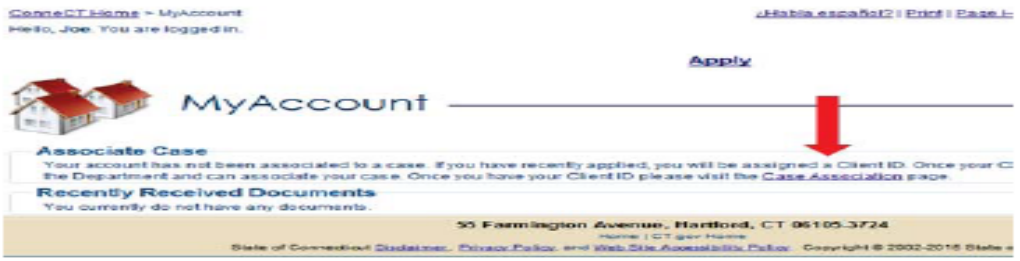
MyAccount: Online Renewals

We are pleased to announce that Online Renewals is up and running on MyAccount! If a customer has set up a MyAccount that has been associated to his or her client ID, *and is within 60 days of a renewal due date*, a link will appear on their MyAccount home page to complete the renewal online. The "Renewals" section is highlighted below. Customers may upload documents with their online renewal at completion. For more information, please visit:
www.ct.gov/dss/renewal



If you skipped typing your client ID in during registration, don't forget to go back and "Associate Your Case."
Benefits of an associated case:

- Current Benefit Details
- Report a Change
- Complete a Renewal



Questions

DDS.Waiver@ct.gov